

General Appendix 12
Cost-Sharing for Participants

	All Kids Assist* 0% - 133%	All Kids Share* 133% - 150%	All Kids Premium Level 1* 150% - 200%	All Kids Premium Level 2* 200% - 300%	Medicaid Adults (FamilyCare Assist, AABD and HBWD)* 0% - 133%	Breast and Cervical Cancer Program	Illinois Healthy Women*	Illinois Veterans Care
CPT Codes 99201 – 99215	\$0	\$3.65/visit	\$5.00/visit	\$10.00/visit	\$3.65/visit	\$0	\$3.65/visit	\$15.00/visit
CPT Codes 99241 – 99245	\$0	\$3.65/visit	\$5.00/visit	\$10.00/visit	\$3.65/visit	\$0	\$3.65/visit	\$15.00/visit
CPT Codes 90801 – 90911	\$0	\$3.65/visit	\$5.00/visit	\$10.00/visit	\$0	\$0	Not Covered	\$15.00/visit
CPT Codes 92002 – 92014	\$0	\$3.65/visit	\$5.00/visit	\$10.00/visit	\$3.65/visit	\$0	Not Covered	\$15.00/visit
CPT Codes 98940 – 98943	\$0	\$3.65/visit	\$5.00/visit	\$10.00/visit	Not Covered	\$0	Not Covered	Not Covered
T1015 (Medical or Dental Encounter)	\$0	\$3.65/visit	\$5.00/visit	\$10.00/visit	\$3.65/visit	\$0	\$3.65/visit	\$15.00/visit
T1015 (Behavioral Health Encounter)	\$0	\$3.65/visit	\$5.00/visit	\$10.00/visit	\$0		Not covered	\$15.00/visit
Family Planning Services Billed with Modifier FP	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Restorative Dental	\$0	\$3.65/visit	\$5.00/visit	\$10.00/visit	Not Covered	\$0	Not Covered	Not Covered
Prescription Drugs (Per 30-day supply)	\$0	Brand \$3.65 Generic \$2	Brand \$5 Generic \$3	Brand \$7 Generic \$3	Brand \$3.65 Generic \$2	\$0	Brand \$3.65 Generic \$2	Brand \$14 Generic \$6
Over-The Counter (OTC) Medications Prescription Required	\$0	\$2.00/drug	\$3.00/drug	Not covered	\$2.00/drug	\$0	\$2.00/drug	Not Covered
Emergency Room Visit	\$0	\$3.65/visit	\$5.00/visit	\$30.00/visit	\$0	\$0	Not Covered	\$50.00/visit
Emergency Room Visit for Non-emergent Service	\$3.65/visit	\$10.00/visit	\$25.00/visit	\$30.00/visit	\$3.65/visit	\$0	Not Covered	\$50.00/visit
Hospital Inpatient Services (Including admissions for substance abuse and mental health services)	\$0	\$3.65/admission	\$5.00/admission	\$100/admission	\$3.65/day	\$0	Not Covered	\$150/admission
Hospital Outpatient Services	\$0	\$3.65/visit	\$5.00/visit	5% of HFS rate	\$0	\$0	Not Covered	10% of HFS rate
Annual Copayment Maximum	\$0	\$100 per family	\$100 per family	\$500 per child	\$0	\$0	\$0	\$0

*No co-payment for Well-Child, Immunizations, Preventive Services, Diagnostic Services or Family Planning. Family planning **related** medical services require a co-pay for office visits.